## STATE OF MARYLAND



January 8, 2015

The Honorable Joan Carter Conway Senate Education, Health and Environmental Committees Miller Senate Office Building 2 West Wing Annapolis, Maryland 21401

The Honorable Peter Hammen Chair House Health and Government Operations Committee House Office Building 6 Bladen Street, Room 241 Annapolis, Maryland 21401

Dear Chairwoman Carter Conway and Chairman Hammen:

We are writing to provide an update regarding our efforts to improve oversight of providers for medically fragile foster care youth licensed by the Department of Health and Mental Hygiene (DHMH) and funded by the Department of Human Resources (DHR). As you will recall from previous briefings, a provider called Lifeline, Inc., voluntarily surrendered their license after a review from DHMH's Office of Health Care Quality (OHCQ) raised concerns. During the time period when the State was planning for the transition of children from that facility, a medically fragile child died.

Since we last wrote to you, an autopsy conducted by the state Office of the Medical Examiner ruled the child's death was the result of complications of cerebral palsy resulting from physical abuse that occurred several years ago at the hands of a family member and prior to him entering care. Additionally, a subsequent mortality investigation by OHCQ did not cite any deficiencies relating to the services provided by Lifeline in the child's death. The autopsy has not yet been released at the request of law enforcement.

With that important information in mind, both agencies have acknowledged that we can always improve our oversight of these homes and we continue to work closely together. To be truly successful, our approach must balance enforcement with increased technical assistance and training for these providers. If we focus solely on enforcement, we run the risk of overburdening providers and staff with additional layers of bureaucracy that hurt our ability to serve these children. If, however, we focus solely on technical assistance and training, we will fail to ensure that we have a reasonable process that ensures accountability for the providers with whom we contract for the day-to-day care of these children.

## Enhanced Training and Technical Assistance

• Provider Training: DHMH (through its Developmental Disabilities Administration) and DHR are working together to provide additional education, training, and technical support to all providers of services for medically fragile children. The State conducted a request for proposals (RFP) process and has awarded the contract to Columbus Medical Services. Columbus has over 30 years of experience and collaborated with more than 140 state and local agencies in more than 40 states. They will start work on January 15 with all three medically fragile providers to assess training needs and assure the key training identified is completed.

The Honorable Joan Carter Conway and Peter Hammen Page 2 of 2

• Individual Assessment of Each Medically Fragile Child: DHR is also working with DHMH to conduct a review of all medically fragile children in the care of these providers. Dr. Rachel Dodge of the MATCH program in the Baltimore City Department of Social Services is coordinating these reviews with staff from Mt. Washington Pediatric Hospital. As you are aware, Mt. Washington is an affiliate of the University of Maryland Medical System and Johns Hopkins Medicine and is well respected for the quality of care they provide. The review, which is expected to be completed by January 16, will include a review or each child's medical records and treatment plans to assess the appropriateness of the level of care provided to each child.

## Increased Oversight and Accountability

- <u>DHMH Task Force Report</u>: The task force has focused on providers that serve medically fragile children and it is assisting DHMH and DHR in clarifying the roles and responsibilities within and between the agencies that have oversight to providers that serve medically fragile children. Bernie Simons, the Deputy Secretary of Disabilities, and Tricia Tomsko Nay, Executive Director and Acting Medical Director of OHCQ, are co-chairing the task force. The Department of Human Resources (DHR) is integrally involved in the parts that relate to services for children in the agency's care. The task force has held two meetings and is holding a third on January 7. We expect it will deliver an initial set of recommendations by the end of January.
- Improved Financial Monitoring: As we have written about previously, DHR has taken steps to improve our monitoring of the financial condition of group homes and foster care providers for children in Maryland. Providers are now required to complete financial incident forms designed to improve financial reporting between audits. These forms are designed to alert the State to common financial conditions that could potentially affect the quality of care. While 95 percent of all providers reported no issues, six providers had unresolved financial concerns. Concerns for five providers were addressed through a corrective action plan. DHR terminated its contract with one child placement agency and successfully transitioned all 33 children to a new provider.
- OHCQ Children's Unit: DHMH has allocated an additional position to OHCQ to coordinate the activities
  of the children's unit and we anticipate that recruitment will begin by February. The new position will
  enhance the Department's ability to ensure the health, safety, and welfare of children being served by
  these providers. Additionally, OHCQ has appointed a Deputy Director of State Programs who will start
  on February 4, 2015.

As we move forward, we will continue to share updates with you. Please contact us if there are any questions.

Sincerely,

Theodore Dallas Secretary, DHR

Mudu Jellas

Laura Herrera Scott, MD, MPH Acting Secretary, DHMH